Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4279HIC	A. BUILDING _____ B. WING _____	04/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMELESS INDIVIDUAL RESIDENTIAL CARE	4617 SANTA MONICA AVE N LAS VEGAS, NV 89032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments This statement of deficiencies was generated as a result of the state licensure survey conducted at your facility on April 3, 2009. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999. The facility was licensed as a two (2) beds Homes for Individual Residential Care Facility which provides food, shelter, assistance and limited supervision for a maximum of two (2) people. The census was one (1) residents. There were no complaints investigated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. No regulatory deficiencies were identified. Please keep a copy of this statement for your records. No further action is required.	H 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE